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# EDITORIALS

## Financing Health Services for Older People

ONE of the most pressing problems in dealing with the health needs of the aged is to finance the costs of the care they need. In 1892 Charles Booth pointed out that "when all is said, the fact remains that age falls heavily on the poor, and that the case of the aged poor demands special consideration." This point is as valid today as it was then and is basic to much of the current controversy on financing health care for older people. In the past health services for the aged were derived from four sources: direct payment by patients, general tax funds, endowments, and insurance. The relative importance of these has changed substantially over the years. Today, payments from public agencies and insurance schemes of various kinds defray the greater part of the expenses.

Since the colonial period local communities in this country assumed responsibility for the indigent ill, including the aged. Based on the charity of hospitals and clinics, or individual philanthropy, or social and religious agencies and the tax-supported poorhouse, the system foundered under the impact of the economic depression of the thirties. Through federal grants-in-aid, the Social Security Act of 1935 made it possible for state governments to give cash assistance to needy persons who were aged and/or disabled. Yet, despite the higher incidence and longer duration of illness in this group, public provision of medical care for it is very uneven. The financing of medical care through public assistance has grown over the past two decades, but the impact of such action on the problem of the aged is limited. In terms of actual medical needs and present-day costs of medical care the federal contribution is quite low. Furthermore, there are specific financial limitations in many states where the philosophy seems to obtain that welfare recipients are second class citizens. Finally, the relationship of prepayment medical care to welfare assistance has hardly begun to be explored as an area for future development.

The role of prepayment in meeting the needs of older people who are not indigent is also limited, due to several causes. One is that voluntary health insurance plans rely to a very large extent on group enrollment, generally through the place of employment. Fur-

thermore, income and age limitations reduce the number of persons eligible to join prepayment plans. Exclusion of preexisting conditions is another limitation, so that such plans meet only part of the medical needs of a certain proportion of seriously and/or chronically ill persons. These characteristics affect the aged to a greater extent than younger groups of the population. These limitations may, in part, be removed in the future by the further development of industrial health and welfare plans, particularly by the growth of the recent tendency to extend benefits to retired employees and in some cases to their dependents.

Even with these advances, however, older people are at a disadvantage. Services they need may not be included in the policies under which they are covered. Moreover, they are poor insurance risks and therefore insurable only at premiums so high as to be beyond their financial means. In general, voluntary prepayment as presently organized will not be able to meet all the needs of older people for financing medical and institutional care. To a greater degree than at present government (federal, state, and local) will have to take steps to meet the increasingly urgent unmet health needs of older persons.

Means can certainly be devised to deal with these problems, but it is clear that there can be no single, simple answer. (The symposium in this issue of the Journal affords evidence on the point.) In the future the financing of health services for most older people will have to be obtained through general taxation, prepayment, and combinations of these approaches. However, the financial problem must not remain isolated; the social and health problems of the aging are interlocked with it. Advances in public health, medicine, and social conditions have made it possible for more men and women to live to be old. At the same time, social and economic developments, among them the growth of industry and the expansion of urban life, have created problems for the older person. Money, personnel, research, community action, interest in older people—all are needed to deal with these problems. Most important of all, however, there must be an all-pervading conviction that what we do to and for others today will have consequences for us tomorrow.

## Marginal People

WHEN John Dewey described personal traits as "functions of social situations," he called attention to a crucial point in the development of personality and in the determination of human behavior. Individual conduct can be organized only if there is some regularity in the behavior of others. From the point of view of the individual, the most general function of social organization is to provide predictability in interpersonal relations. Otherwise the individual has no way of knowing where he stands; the social ground under his feet lacks stability and solidity. This crucial point has been developed by a number of investigators—including Émile Durkheim, George H. Mead, Robert E. Park, Muzafer Sherif, Kurt Lewin, Harry Stack Sullivan, and others. It has been found that when individuals are subjected to rapid and important shifts in social orientation so that it is difficult to know what to expect, they develop erratic behavior and evidence of emotional disturbance. Some of the consequences of such situations may be observed among uprooted and socially mobile populations, particularly in the personality type which has been characterized as the Marginal Man.[1]

Introduced by Robert E. Park, the Marginal Man was conceived as "one whom fate has condemned to live in